Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Miglustat

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this an initial or continuation request? If an initial request, go to 2. If continuation request, go to 6.

☐ Yes ☐ No

Q2. What is the diagnosis?

☐ Gaucher Disease Type 1 – Go to 3 ☐ Niemann-Pick Disease, Type C – Go to 5

Q3. For Gaucher disease, was the diagnosis confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or by genetic testing? Please attach documentation.

☐ Yes ☐ No

Q4. Does the patient have a documented inadequate response to, intolerable adverse events with, or a clinical reason to not use enzyme replacement therapy (e.g., allergy, hypersensitivity, poor venous access)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. For Niemann-Pick disease, type C, has the diagnosis been confirmed by genetic testing results showing mutations in NPC1 or NPC2 genes? Please attach documentation.

☐ Yes ☐ No

Q6. For continuation, is there documentation showing that the patient is not experiencing an inadequate response or any intolerable adverse events from therapy?

☐ Yes ☐ No

Q7. Additional Information:

_____ _____

Prescriber Signature Date

v2025